Jon Watts Denture CLinic

COVID-19 Pandemic Denture Treatment Consent Form
(to be completed on day of first scheduled appointment and signed every appointment there after.)

Patient name: _____

I understand the novel coronavirus causes the disease known as COVID-19. I understand the novel coronavirus virus has a long incubation period during which carriers of the virus may not show symptoms and still be contagious.

I understand that due to the frequency of visits of other denturist patients, the characteristics of the novel coronavirus, and the characteristics of denture procedures, that I have an elevated risk of contracting the novel coronavirus simply by being in a denturist office. _____(Initial)

I confirm that I am not presenting any of the following symptoms of COVOID-19 identified by BC Ministry of Health:

- Fever > 38°C _____(Initial)
- Cough _____(Initial)
- Sore Throat _____(Initial)
- Shortness of breath _____(Initial)
- Flu –like symptoms _____(Initial)

I confirm that I am NOT in a high-risk category, including: diabetes, cardiovascular disease, hypertension, lung diseases including moderate to severe asthma, being immunocompromised, having active malignancy, or over age 65. _____ (Initial)
OR
I fall into the following high-risk category (_____) and my denturist and I have discussed the risks, and I agree to proceed with treatment. _____ (Initial)

I confirm to the best of my knowledge I am not currently positive for the novel coronavirus. _____(Initial)

I confirm that I am not waiting for the results ofa laboratory test for the novel coronavirus_____(Initial)

I verify that I have not returned to British Columbia from any other province or any other country outside of Canada whether by car, air, bus or train in the past 14 days. _____(Initial)

I understand that any travel from any outside of Canada or BC, including travel by car, air, bus or train, significantly increases my risk of contracting and transmitting the novel coronavirus and that BC Ministry of Health requires self-isolation for 14 days from the date a person has returnedto Canada. _____ (Initial)

I understand that BC Ministry of Health has asked individuals to maintain social distancing of at least 2 metres (6 feet) and it is not possible to maintain this distance and receive denture treatment. _____ (Initial)

I verify that I have not been identified as a contact of someone who has tested positive for novel coronavirus or been asked to self-isolate by BC Ministry of Health, the BC Centre for Disease Control or any other governmental health agency. _____(Initial)

LIST OF DENTURE TREATMENT REQUIRED:

_____

_____

I verify the information I have provided on this form is truthful and accurate. I knowingly and willingly consent to have the above-listed denture treatment completed during the COVID-19 pandemic. **(Please complete this on your treatment day only.)**

_____
SIGNATURE OF PATIENT

Printed Name_____ Date_____

Signature_____ Date_____

Signature_____ Date_____

Signature_____ Date_____

Signature_____ Date_____

Signature_____ Date_____

Signature_____ Date_____

Signature_____ Date_____